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Midwifery in India and its Roadmap

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Abstract

Healthy women are the key to the health of any nation. Midwifery in India has climbed up the ladder of progression from before independence till the present day. In the pre-independence era, maternal and newborn care was given by indigenous *dais* who not only helped during childbirth but also acted as consultants for any condition of the mother related to birth. They were midwives in the literal sense. Over the time, midwifery in India has broadened to the presence of a skilled birth attendant during childbirth. The maternal health status of women and maternal mortality are closely related to the presence of trained attendants at birth and it has become the single most important factor for achieving safe motherhood. With the introduction of several strategies like the Janani Suraksha Yojna (JSY) and Janani Shishu Suraksha Karyakaram (JSSK), by the Government of India lately, there has been an increased emphasis on the role of the nurse midwife. With the increasing focus on reduction of maternal mortality, strengthening midwifery services both in number and quality is the essential missing step on the roadmap to maternal health.

Keywords

Midwifery in India, Maternal Mortality, Skilled Birth Attendant and Skill Labs

Introduction: midwifery in India

Healthy women are the key to the health of any nation, primarily because of their vital role in co-creating healthy infants and co-caring for the family. Providing health care to women is not only a health issue but a matter of human rights issue. In women's life childbirth is a special event. A mother will never forget a 'midwife' who delivered her baby; and who was 'with the woman' during childbirth, which is the very essence and identity of a midwife. Hence a midwife is an obvious catalyst in providing safe motherhood in the fabric of our society. This paper sets out the situation of Indian midwifery in three sections:

1. Midwifery in India before independence.
2. Midwifery in independent India
3. Present and future of midwifery in India

Midwifery in India before independence

Midwifery is a profession with a long history that has progressed alongside with the evolution of mankind. Women have been 'with women' during the most intimate and significant events of their lives. In ancient India, care of women and practice of midwifery were totally in the hands of indigenous village 'dais'. These indigenous dais, not only helped during childbirth but also acted as consultants for any condition of the mother related to birth. They were midwives in the literal sense.¹⁻²

When medical missionary women from England came to India, the first striking observation they made was that, since dais were unable to deal with difficult deliveries and pregnancies, the maternal and neonatal mortality were very high.¹

The first training school for dais was started in 1877 by Miss Hewlett, an English missionary of the Zenana Missionary Society. However, the training of dais was not taken up by Government of India (GoI) till 1900 when a fund was established by Lady Curzon to improve the conditions of childbirth in the country.¹

But before that, in 1872, a handful of Indian Christian nurses were trained for two years at Delhi. In 1899 the Zenana Bible and Medical Mission started the training of nurses, but until 1893 there was no generally accepted scheme of training in the hospitals.¹

In 1918 with the help of Dufferin Fund, Lady Reading Health School was established to train Auxiliary Nurse Midwives (ANMs). In 1926 the Madras Registration of Nurses and Midwives Act was passed to promote the role of a registered midwife for service during childbirth.¹

In 1936 Dufferin fund sanctioned grant to a number of Dufferin hospitals to build hostels, supply teaching materials and employ qualified sisters in nursing schools. Thus Dufferin fund helped in raising the standards of nursing and midwifery in India.¹

In fact prior to independence, midwifery training started as a separate course, in India. Young girls at the middle school level (8th) were selected to undergo this training.¹

Midwifery in independent India

In 1946, the Bhole Committee laid stress on the need for qualified midwives, health visitors, and the training of *dais*. In 1955, the Shetty Committee recommended the training of Auxiliary Nurse Midwife (ANMs) in health centers for maternal and child health services, provided there were adequate health visitors to supervise them. In 1959 Bishoff, a technical Consultant supported the training of two types of nursing personnel- ANM and General Nurse Midwife (GNM Nursing- 3 years and Midwifery- 1 year). After independence, tremendous changes have been brought in nursing education in the country.⁷

In 1947, the first step the Indian Nursing Council took after its inception was to combine the nursing and the midwifery courses into a single course. The course was designed to be of three and a half years duration, with the entry qualification being 10th class.¹

In 1975 the Kartar Singh Committee recommended shortening the two year course of ANM to one and a half years and entry after class 10th. These ANMs were designated as female health workers. They were specially trained in midwifery and child health care services. GoI also invested heavily in the training of *dais*.¹

Present and future of midwifery in India

The presence of a skilled midwife at birth is the single most important factor for achieving safe motherhood (WHO).³ The number of midwives available as per population is an important indicator of the maternal health status in a country. The maternal health status of women and maternal mortality are closely related to the presence of trained attendants at birth. As the percentage of births attended by trained personnel goes up, the maternal mortality ratio goes down.⁴

In India there are the following cadres of midwives:

1. The trained nurse midwife (RN, RM): Who has undergone a diploma (Diploma in General Nursing and Midwifery), which is of three and a half years duration.
Or
A degree nurse who has done B.Sc. (Honors) Nursing, which is of four years duration.
2. The ANM, who is designated as the Multi-purpose health worker (female), is registered as a midwife. Presently, this is a two years course with entry classification being 12th class. India has a huge cadre of ANMs who are educated and trained in Midwifery. Unfortunately, they conduct only 12% of the deliveries. This is due to the fact that programme priorities have emphasized Family Planning (FP) and immunization as their main work and have neglected delivery care. India also has a large number of Primary Health Clinics, Community Health Clinics, and rural hospitals that can also provide delivery care. But, here again, the priority in the past and present has been FP and immunization. Thus, these priorities should be re-oriented so that each level of health infrastructure offers maternity care as one of its basic services.¹
3. Skilled Birth Attendant (SBA) refers exclusively to people with midwifery skills (e.g. doctors, nurses, midwives), who have been trained to get proficiency in the skills necessary to manage normal deliveries, and to diagnose, manage, or refer complications to all levels of health care settings.³
4. Midwifery skills are defined as a set of cognitive and practical skills that enable the individual to provide basic health care services throughout the natal continuum period and also to provide prompt actions in emergencies including life saving measures, when required.⁴

The skilled birth attendant, as a prime provider of normal maternal and newborn care, needs to meet certain criteria

1. Having a certain level of competency in life saving skills and managing emergencies.
2. Being technically up to date with regard to evidence based practice.
3. Maintaining practice in these skills.

Although there are a few exceptions but almost all the countries where the number of skilled attendants is more than 80%, have a Maternal Mortality Rate (MMR) below 200.⁵

The GoI is piloting the development of a new cadre of private practitioners called community SBA. Such a cadre was mentioned briefly in the National Population Policy 2000. These community SBAs will be educated women chosen from the community and trained for about one year in midwifery by GoI, and they will be allowed to practice midwifery in the community. Although they will not be the employees of the GoI, the government may support them by providing some start up inputs to set up their practices.⁶

In April 2003, the GoI introduced a new strategy called the Janani Suraksha Yojna (JSY). It is an amalgamation of schemes such as the National Maternity Benefit Scheme, transport money for emergency cases and referral fees for dais. Under JSY, families below the poverty line will receive money for delivery at a Government institution, the TBA facilitating the institutional deliveries would be compensated and the transport will also be paid.⁶

Even though skill based training is being conducted but the health professionals are not being able to utilize their skills optimally; one of the reasons for this is lack of re-orientation on the skills learnt.

For this, skill labs, with a standardized set of skill stations, focusing on the competencies of the health personnel, are needed. With this objective the GoI has taken the initiative to establish such skill labs across the country.⁶

Need for midwifery as a profession in India

1. To achieve safe motherhood

India's health care system for rural areas follows a hierarchical system of technical skills, facilities and personnel. The primary health centers set up for every 30,000 people are expected to be the referral and supervisory supports to the sub centers and villages. For several years now, there is a strong realization that the PHCs have not served this vital function due to lack of a qualified obstetrician or lady doctor who could handle emergencies. It is unrealistic to expect specialist services in villages, although 60-70 % of population lives in rural India, the provision of skilled professional midwives with training in life saving procedures and facilities to implement these would be more practical to achieve targets of safe motherhood.¹

2. To avoid duplication of services

In normal cases certain things are done by doctors as well as by midwives. Obstetricians are busy in taking the load of normal cases, which midwives can very well take care of so that obstetricians can devote quality time to high risk cases.

3. To give health education

Health education should be provided so that people are more receptive to have deliveries conducted from professional midwives. Prevention is better than cure is well known. In the field of midwifery there are plenty of problems which can be solved if proper teachings are given to mothers at all stages of the maternity cycle.

4. To participate in country's concern i.e. maternal and child welfare

MMR is a sensitive indicator of any country's health status. Creation of a cadre of professional midwives and auxiliary midwives with lifesaving skills will be really helpful.¹⁰

5. To get status and recognition in the society

Status of midwives is very low; midwifery is still a branch of nursing and an appendage of obstetrics. Hence there is an urgent need for midwifery to take on a more serious and independent identity in view of the crucial nature of its role in the health of mothers and children and in the reduction of MMR.¹⁰

In short, for rich or poor, in every sphere, professional midwives are needed.

Recommendations - points for Implementation by the state government

With the launch of the National Rural Health Mission, with schemes like JSY, Janani Shishu Suraksha Karyakaram (JSSK), there is an increased emphasis on the role of the nurse midwife. Hence, in order to have consistent and competent quality care, a

comprehensive roadmap of midwifery is urgently needed. Some recommendations for the same are as follows¹:

1. Develop and strengthen ANM/GNM schools and State Nodal Centres as per GOI Road Map.
2. Make six-weeks training compulsory, as an induction course, for newly recruited faculty.
3. GOI to give commitment for filling up vacant positions on a priority basis and for sanctioning faculty positions as per the Indian Nursing council (INC) guidelines.
4. Incentives and higher salary can be given for attracting qualified faculty from other states to bridge the shortage.
5. Faculty must have minimum 3-5 years clinical experience prior to becoming as faculty. Regular and structured knowledge and skills up-gradation of ANM and GNM faculty should be organized through refresher courses/ Continuing Nurse Education (CNE).⁷
6. High case load facilities can be identified as clinical sites for training. CHC-Family Referral units (FRUs) with high case load may also be explored as clinical training sites for attaching the students for clinical experience, since nursing schools attached with DHs and MCs do not get sufficient hands-on practice.
7. Nursing faculty, Obstetricians, Paediatricians and other clinicians should discuss and implement clinical skill standardization in hospitals attached to the nursing schools to be used by the nurse midwives for their practicum.⁷
8. Nodal persons at clinical sites, for example matron, clinical preceptor/ instructor, should supervise the students on the 'hands on skills' performed at clinical sites. Nursing students should also be given enough opportunity for hands-on practice.⁴
9. Skills lab development in the states needs to be fast tracked.
10. Institutions should be graded, as A/B/C/D category – and this should be displayed on state website.
11. District Headquarter (DH) should be the examination center for all competency based certification and a regulation to this effect needs to be issued and followed up by State Nursing Council for strict compliance.
12. Create and fill posts of district and block PHN
13. Monthly meetings of skills birth attendants should be utilized for knowledge and skills enhancement.
14. Implementation of career development paths should be fast tracked.
15. Strengthen the Nursing representative bodies in state directorate
16. There should be better co-ordination between the directorate and the nursing council for improved outcomes.
17. There should be representation of nursing personnel in the executive committee meetings under National Rural Health Mission at all levels of institutions.
18. The district nursing official/ Public Health Nurse (PHN) at district level should look after the administrative issues of field nurses to provide supportive supervision and management of data.⁶
19. Develop e-learning modules for nursing personnel in management, accounting and leadership.
20. Soft skills' training is needed.
21. Exposure visits for Mission Directors and State Nursing Officials to Christian Medical College, Vellore for learning the models of nursing practices.

Similarly, we need to strengthen the supervisory structures at the district and block levels to enhance the technical capacity of nurses and ANMs. To achieve this there is a need to create posts of district and block PHNs and at least one Lady Health Visitor to supervise six ANMs.

Conclusion

With the increasing focus on reduction of maternal mortality, strengthening midwifery services both in number and quality is the essential missing step on the roadmap to maternal health. The nation needs to urgently work hard to strengthen midwifery in India.

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List of abbreviations

ANM	-	Auxiliary Nurse Midwives
CHC	-	Community Health Centre
CNE	-	Continuing Nurse Education
DH	-	District Headquarter
FRU	-	Further Referral Units
INC	-	Indian Nursing Council
JSSK	-	Janani Shishu Suraksha Karyakram
JSY	-	Janani Suraksha Yojna
MC	-	Maternity Centers
MMR	-	Maternal Mortality Rate
NRHM	-	National Rural Health Mission
PHC	-	Primary Health Centre
PHN	-	Public Health Nurse
SBA	-	Skilled Birth Attendant
TBA	-	Trained Birth Attendant